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The implications of medical ethics

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In this paper, Mr Thompson, one of the research fellows appointed to the Edinburgh Medical Group research project, seeks to define medical ethics in relation to traditional ethics in the philosophical sense of enquiring into right and wrong modes of thought and conduct, and to carry that study further into the field of moral decisions made by doctors and other professional people who care for the sick. Until very recently the Victorian definition of medical ethics – medical etiquette – served the doctor well but the complexity of modern medicine and the involvement of other professional workers in medical care appears to have swept away the old framework and left a vacuum. A new medical ethic must be evolved to fill that vacuum, taking account not only of technological advances but also of relationships between doctors and other professionals associated with them and of the role in caring for the sick.

A definition of 'medical' ethics

Medical ethics could be defined simply as the area n which concern is expressed about the moral questions which arise in the caring professions – questions which are not adequately answered either by the traditional 'ethics' of the relevant professions, or by the teachings of the church, or by the policies of successive British governments in relation to the National Health Service, or by academic moral philosophy. The very nature of medical ethics is problematic, to say the least. The juxtaposition of 'medical' and 'ethics' implies that we are dealing with some sort of hybrid discipline; and this suggests in turn that we need to consider what sort of method is appropriate to its subject matter, as distinct from other disciplines.

The nature of the contemporary issues and the crises of responsibility which they raise for many people, both professional and lay, demonstrate the inadequacy of traditional medical ethics. The solutions to these problems are not to be found in the criteria for regulating medical conduct and interprofessional etiquette, which have provided the *raison d'etre* for the General Medical Council and local ethical committees. A responsibility confronts us all to find the basis on which an informed and critical discussion of the moral dilemmas facing members of the caring professions can be conducted in such a way as to involve meaningful dialogue with other professions and the general public. The establishment of a recognized forum for the conduct of such a debate at a national and local level is necessary to avoid resort to arbitrary (though perhaps courageous) personal solutions, or to a simple reliance on legal reform to shift the burden of moral responsibility from the professionals back to 'the public'.

The very nature of the personal moral responsibility demanded of individuals (or groups of individuals) in making difficult moral decisions in clinical practice makes moral intervention from the outside – from the church or the state, from lay pressure groups or commercial interests – both irrelevant and impertinent. This is so as it is of the very essence of such dilemmas that they are not susceptible to generalization or subsumption under one law or moral rule. In the cases of genuine moral dilemma, demanding new solutions, there are, *ex hypothesi*, no single rules which apply and yet there can still be intelligent discussion of cases and an accumulation of practical wisdom and experience in handling analogous situations.

Contemporary academic moral philosophy does not have the virtue of being able to give much assistance in the resolution of such urgent existential dilemmas. In fact, the reaction of the medical profession to most contemporary philosophy is contemptuous for its pedantic irrelevance and critical of the tendency of philosophers to abrogate their responsibility for the critical examination of the substantive problems of ethics. Philosophers appear to take refuge in meta-ethical description of the 'constitutive' and 'regulative' principles of moral discourse as such or in sophisticated discussion of the trivia of the logic of the language of morals, thus avoiding the problems of our historical situation and the concrete dilemmas of individuals. What is demanded is practical moral wisdom, not theoretical knowledge, however sophisticated.

A new consciousness of moral problems by the medical profession

Faced with the growing number of problems in medical ethics, educational establishments providing scientific training in medicine and related disciplines are being forced to reexamine their priorities and to question the assumption that scientific knowledge and technical education do

entirely avoid making value judgments. Because scientists have tended to eschew questions of meaning and value in their quest for purely factual and pragmatic criteria in scientific practice, they have ignored the socio-political and economic forces which determine the context in which they operate and many of the choices they make. They have disregarded the truth that what we choose to regard as 'relevant' facts and 'significant' or 'useful' procedures are determined by prior decisions of value and 'ideological' beliefs which provide the horizon of meaning within which we perceive a problem. This deliberate neglect of questions of meaning and value has left individuals peculiarly vulnerable when they encounter serious moral dilemmas in the course of professional life. What is slowly emerging is a new consciousness of these problems as they are focused for the whole scientific community in the dilemmas of medical ethics.

The challenges raised by the study of medical ethics relate to the determination of the proper point of view from which to approach medical ethics; the recognition of the peculiar subject matter of such a discipline as a normative cultural science; the adoption of an appropriate methodology for the subject; and the acceptance of the fact that the teaching of the subject may require a radically different educational approach.

The Greek approach to medical ethics

In general the approach required would seem to be closer to that of the Greeks than to any modern academic discipline. They recognized that the hiatus between public law and private moral sentiment can only be bridged by the creation of a public forum for the critical discussion of moral issues. The methods required are those of a kind of Socratic enquiry: the traditional means for the clarification of moral issues, namely, the critical interrogation of the experts and sustained public and rational debate, aimed at the definition of the issues and the criteria appropriate for deciding them (see Plato, *Protagoras and Meno*[1]). This traditional approach agrees with the spirit of Hippocrates who insisted that 'every physician should be a philosopher', that is to say, that he should constantly be engaged in the critical reappraisal of the attitudes and values on which his professional practice is based.

FOUR REQUIREMENTS OF THE GREEK APPROACH

There are four requirements of such an approach, which seem to agree with the particular needs felt in relation to medical ethics. These can be conveniently summarized from *The Nichomacheun Ethics*[2] *of Aristotle*:

1) 'Ethics should be based on the study of the actual moral judgments of men of experience . . . men of general culture . . . versed in the practical business of life.'

2) We should recognize that it is 'a study the end of which is not knowing so much as doing'.

3) That 'in studying this subject we must be content if we achieve as high a degree of certainty as the matter of it admits . . . we must be satisfied with a rough outline of the truth, with broad conclusions'.

4) That the goal we aim at is the 'objectivity' of some measure of public consensus, 'inter-subjective agreement', in the formulation of relevant general principles, values and criteria to support our value judgments and moral decisions.

If we start in medical ethics with the actual moral judgments of medical practitioners, nurses and other health care professionals, this has the advantage of empirical veracity and immediate relevance. It also safeguards against the imposition, from the outside, of an alien methodology, or the tendency to make the data fit a preconceived schema rather than to develop categories and schemata as we go along appropriate to the subject matter being examined.

The basic level of problems concerns the dilemmas which arise for individual professionals when they sense that there is a conflict between their private moral convictions and what they believe is required of them in the exercise of their professional roles: such, for example, are the dilemmas of individual doctors or nurses about specific cases of abortion or euthanasia.

The next level of problems arises when different professionals encounter one another in an area requiring interprofessional cooperation but where the attitudes, values and goals proper to one profession appear to conflict with those of another: such, for example, are conflicts between different professionals about telling the truth in relation to dying patients or about the allocation of resources.

The third level of problems is seen when there is a conflict between the ethos of the health care professions and conventional social morality or declared social policy.

The first level of problems demands an approach which is: *a*) informed by the relevant level of medical expertise, *b*) based upon cases and directed towards the development of a tradition of medical 'jurisprudence' and *c*) concerned with the structure and psychology of decision making in actual clinical situations.

The second level of problems demands an approach which is: *a*) interprofessional in character, *b*) based on an awareness of the sociological factors and the pervasive influence of the medical model in the socialization of health care professionals and *c*) directed towards experientially based learning about the psychodynamics of group functioning and

[1]Penguin Classics: London 1956-66.
[2]Published by the Oxford University Press.

the formation of personal and professional identity.

The third level of problems requires: *a*) greater sophistication in the appreciation of the politics of professional and academic life, *b*) a keen appreciation of the key role of 'ideological' factors in defining the character of professional attitudes and values, and *c*) understanding of the variety of 'world views' or 'ideological' points of view represented in a complex society and the need to provide democratic means for the representation of different conflicting interests and minority points of view as well.

Although a great deal of time and attention must be given to study in the area of the first two groups of problems, it is arguable that the discussion of the nature and role of 'ideological' factors must form a basic part of any study of medical ethics. We recognize readily that problems in political life relate in large measure to the different interests men bring to bear upon social problems and the different ideological standpoints from which they approach them. We do not readily recognize that analogous 'ideological' factors play a vital part in the 'politics' of academic and professional life and form the basis of the 'ethics' of the different professions. Thus the examination of the decisive role of ideological beliefs (whether recognized or not) in determining our basic attitudes concerning meaning and value must form a fundamental part of a discipline concerned in the first instance with questions of meaning and value.

Training in medical ethics

It follows from this outline of the scope of medical ethics that training in medical ethics, like training in the exercise of moral responsibility in other areas of life, is complex and may be difficult to formalize into an academic course even if that were thought desirable. The traditional context in which the doctor or nurse receives their education in the exercise of moral responsibility is identical with the context in which they serve their apprenticeship in the exercise of clinical responsibility. But it is arguable, especially in the light of recent developments, that the ethical component in medical education must become more explicit. However, one of the methodological consequences of the adoption of an 'Aristotelian' approach to medical ethics would be that education in medical ethics should be as closely integrated into the ordinary theoretical and practical training of doctors and nurses as possible. It should not just be tacked onto the ordinary curriculum as another optional extra. For ideally 'medical ethics' stands for an approach to medical education as a whole which is informed by a deeper concern for questions of meaning and value than recent 'scientific' training in medicine has allowed.

Medical ethics as the locus of change in social ethics

The context in which the medical profession has come to exercise an unprecedented influence on social attitudes and values is that of a society in which traditional moral attitudes have been subject to unprecedented change and transformation. Medicine is by no means the only or primary agent of this change, but it has been perhaps the most important source of new hopes for the general improvement of man's quality of life and for the realization of new possibilities.

The new medicine has had a decisive effect on social ethics both with respect to the way it has enhanced man's freedom, and by opening up new possibilities for human self-fulfilment. It has enhanced man's freedom by reducing certain risks and inhibiting factors which have limited man's freedom of action in the past and by increasing the degree and extent of his control over his own life processes. Relating to the former we have freedom from ignorance and superstition, freedom from fear and freedom from pain. Mere knowledge itself has a liberating effect: 'Every step forward in knowledge has an exorcising effect' (Tillich, 1951). Reliable diagnosis and prognosis allay the anxieties and irrational attitudes associated with ignorance of life processes and the aetiology of diseases. The fear of infection, the fear of pain, the fear of unwanted pregnancies, the fear of insanity have all been reduced by advances in medical science and technique, with corresponding benefits in the liberation of man's spirit. But perhaps it is the developments in analgesia which have done more than anything in the history of mankind to liberate men from the crippling effects of pain, thus releasing millions of people to continue to live productive and useful lives in spite of their ailments, and has meant too that people have more hope of dying with dignity and in relative comfort.

The revolutionary developments in therapeutic techniques have not only created dilemmas for members of the health care professions, but have created doubts about the old taboos and new hopes and opportunities for ordinary men and women. For many the new medicine is causally connected with the new atmosphere of liberation and permissiveness – especially in the area of sexual ethics – and medical students and nurses are associated in the mind of the public with this tendency, both as its apostles and exemplars.

The appeals made by health care professionals to the public, through the mass media, are ostensibly a sort of *cri de coeur* on the part of such professionals for help from the public to decide, or help to resolve, some of the pressing moral problems which modern medicine and social welfare services have raised for them, problems which they carry for the most part as their private burden. In

practice, however, the concern expressed by members of the caring professions about many controversial and sensational issues, for example, organ transplantation, has ambiguous moral consequences for the public. Their concern has been a potent means of raising the level of public awareness about these issues, has created a significant body of public opinion on moral issues in health care and social welfare, and has made people more aware of their rights and their responsibility to claim and exercise these rights (John XXIII, 1965). Also it has created new anxieties in the minds of people making them critical of the assumed omnicompetence of the professionals and caused them to doubt the right of professionals to decide key moral issues by themselves, especially where their decisions affect the lives and wellbeing of their patients. While in some cases people would prefer the decisions to be left exclusively to the professionals and are afraid of the consequences of knowing and the responsibility of having to share in making the decisions themselves, others are beginning to express with growing vehemence their right to know and express too the growing realization that the professionals alone cannot and ought not to have the full responsibility for deciding these vexed questions, or for determining the moral and political priorities of the National Health Service. Thus there is a growing number of 'lay' people who demand representation on committees for deciding health care policy and specific ethical questions but who also recognize their duty to share with the professionals the heavy responsibilities of making decisions in matters relating to the health and wellbeing of the whole community.

Key methodological issues in medical ethics

A fundamental issue concerns our general point of view, the question of what logic we adopt for the analysis of moral issues in medicine. The traditional logic of science, which has developed side by side with empirical and quantitative science, is well suited to its purpose – accurate calculation and prediction of results based on precise observation, exact description and measurement. This 'extensional' logic is concerned with quantifying the relationships between 'propositions' and 'facts' without enquiring too closely into what is meant by a 'proposition' or a 'fact'. When challenged to say what they are, the scientist or self-styled scientific logician tends to fall back on formal analytical proofs which confirm the consistency or coherence of his logical calculus without being able to prove the facts; or he falls back on the lame justification of facts as facts, namely, they must be the facts because the explanation they generate 'works' which does not justify the validity of the choice of the logic on which the explanation is based.

Once we ask questions about the meaning of our conceptual structures we need a different kind of logic, an 'intentional' logic which can do justice to the many different kinds of human intentions – the variety of meanings, purposes and values we express by means of our actions, words and thoughts. If it is sometimes necessary to use such a qualitative logic in the technical areas of philosophy and science, where evaluative judgments are made in relation to fundamental questions of theoretical stance or orientation, then *a fortiori* it is necessary and important to recognize that any adequate discussion of an evaluative discipline such as medical ethics must be based on an 'intentional' logic (Parker and Veatch, 1959).

Clinical judgments in medicine are never entirely value neutral, because they involve human beings making decisions which affect other human beings; but this does not make all clinical judgments into value judgments or crypto-moral judgments, for they are not judgments of value or about values nor do they explicitly involve moral decisions. But what this does mean is that clinical judgments are exercised by an individual within a horizon of meaning and values which are defined with increasing precision as we move from his overall world view, to his professional outlook, to his private point of view with respect to moral values and his private code of conduct. All three are implicitly involved each time he makes a specific clinical judgment as doctor in relation to a specific patient.

In practice we tend to 'de-intentionalize' clinical judgments by considering them in abstraction from the specific historical and existential situation. For example, instead of considering the specific details of the case where Dr Scott examines and treats Mrs Smith in the Royal Infirmary, under specific conditions, in the company of specific staff, at a specific time etc, this becomes the case of patient x with complaint y, treatment prescribed z. In this way it is possible, theoretically but not in practice, to ignore the questions of meaning and value which provide the ambience of the action and judgment.

Outside the narrowly defined and specific context in which clinical judgments could be regarded as purely clinical, doctors and nurses, psychiatrists, chaplains and social workers cannot avoid making moral choices and value judgments. The self-styled 'scientific' and 'objective' approach, which avoids and evades the questions of meaning, attitude, goal and value, is simply unscientific and subjectively biased when it comes to the detailed examination of real-life situations in clinical practice. Part of the reason why this is not readily recognized is that we tend to understand 'values' and 'morals' in too narrow, moralistic and caricatured a way which confuses morality with the private tastes, likes and dislikes of people rather than seeing it as relating to the whole fabric of our relations with other people. In addition, there is a

tendency in the course of professional training for the moral character of certain judgments to become obscured because the situations to which they relate are so common and unproblematic that the responses to them become routine and automatic with the accumulation of experience in clinical practice. We tend to be conscious of the moral character of our judgments only when we encounter problematic situations or dilemmas involving conflict of principles. The result is an overdramatic approach to medical ethics and a tendency to ignore the nature and structure of moral decisions in ordinary and normal situations, with resulting confusion about the characteristics and requirements for sound moral judgment.

The example of academic moral philosophers is not very helpful here. For, instead of concerning themselves with the nature of day-to-day decision making in moral situations, they have tended to focus attention on the conflicts which arise when there is a clash between different value systems, and the rare and somewhat exceptional circumstances when we feel compelled to choose between them. Related to this has been the tendency to be preoccupied with the extremely abstract problems involved in the ultimate justification of a value system as a whole, and the various reductionist theories which have been adduced to meet this demand. The modern tendency to be concerned with the meta-ethical analysis of the 'language of morals', with a view to characterizing its 'logic' and 'semantics', might appear to be closer to our demand were it not for the fact that such philosophers tend to opt out of the discussion of the substantive issues in ethics, rather contemptuously suggesting that 'moralists', not 'moral philosophers', should be concerned with such issues. In addition their concern with the 'logic of moral discourse' involves too often the attempt to force moral discourse onto the procrustean bed of an extensional logic which is ill adapted to the needs of discourse about values, rather than any serious attempt to characterize its own inherent logic (Hare, 1952; Nowell-Smith, 1959).

The very urgency of decisions in clinical practice makes much of this irrelevant. The proper identification of the concrete components and factors in clinical situations requiring some kind of moral decision is an urgent practical requirement for clear-headed and balanced judgment. The theoretical analysis of moral judgments as such, abstracted from the real-life context in which the judgment is made, ignores the structure of relations which give the judgment its significance. The coordinates of the judgment are the basis for its reliability as a judgment of value, and the values, if they are to be discovered anywhere, are to be discovered in the fabric of relationships which make up the situation.

Again we can profit from a recognition of the commonsense of Aristotle's approach and analysis of judgments and actions in terms of the causes – means – ends structure of intentional acts. Under 'causes' we have to consider the given structure of the situation which provides the context in which an existing professional agent and specific patient stand relative to each other, as well as the subjective conditions which determine the way people act and react with one another. Under 'means' we have to consider the available personnel and resources and the various possible courses of action open to us, as well as the opportunities and possibilities of the situation. This includes the skills and limitations of those involved and the variable circumstances in which a course of action will be worked out. Under 'ends' we have to consider the variety of ambiguous consequences arising from the application of different courses of action and the often unpredictable character of the results in many cases because of our limited scientific knowledge and the capriciousness of people.

The task of learning how to assess the relevant causes, means and ends and to make an intelligent application of principles would be overwhelming if it were not for the fact that so much of what is involved is 'second nature' to us. Recall is only necessary when there is a particularly intractable dilemma which requires self-conscious examination and analysis. The recognition that choices have to be made, and regularly are made by individuals or groups, and that these have some recognizable features of form and content, means that we can reflect upon them and study them and that the vague generalizations which it is possible to build on the study of cases must serve, and do in fact serve, as the basis of moral education in clinical practice. Even if our capacity to rationalize these highly complex situations may be limited and the relativities involved seem overwhelming, this is the task of medical ethics.

Aristotle's definition of prudence as 'the wise discrimination of means, in the light of principles, in the contingency of the actual situation, with a view to obtaining the best possible end' could well be taken as the motto of medical ethics. Because of its intuitive realization of the importance of prudence, the medical profession has perhaps been rightly conservative about the introduction of courses in medical ethics, believing by instinct that the best education a doctor or nurse could have in medical ethics is the actual experience in clinical practice where, in theory, the trainee learns through trial and error the best way to apply moral principles in specific situations.

However, given the fluidity of the present situation and the lack of definition of the principles to be applied, together with the urgent need to decide when to use and when not to use the already available technical means, this attitude is not good enough, and this *laissez-faire* approach to medical

ethics simply entrenches a conservative approach and does nothing to solve any of the new dilemmas. What is required is the clarification of the issues involved through proper interdisciplinary and interprofessional discussion and the articulation of a new kind of collective wisdom on these matters which can serve as a basis for the guidance of trainees.

The framework for moral choices

The plurality of 'ethics' in the various professions, in the sense of convergent and divergent attitudes, values and goals, as well as the diversity of ethical views in society at large, demands a clearer understanding and definition of the framework within which we make moral choices, with a view to identifying the constant factors in moral decisions. Ideally this task ought to be undertaken by representatives of the different professions who may be involved in clinical situations in the hospital and community, so what follows is a tentative outline based on a seminar held in 1975 in the University of Durham involving philosophers, psychologists and other students.

It is not in philosophy but in psychology and sociology that discussion has returned to the consideration of these constant factors in making moral decisions, constant in the sense that they are always present as components in our psychological and social experience, in spite of having varying content for different people at different times and places. These have been characterized as: 'situations', 'personae', 'arbiters' and 'rules'. Together these form the 'cognitive matrix' within which we have to make moral decisions.

RULES

In nearly all discussions of ethics, too much attention has been given to rules. In fact, for many people, ethics is simply about rules, nothing more. Insufficient attention has been given to the way rules are formulated in actual practice, how they have to be applied with a subtle understanding of the complexity and often contradictory demands of the same situation, of the different expectations of different authorities and arbiters, of the different responsibilities attached to different roles which may be exercised by the same person. However, we cannot afford to neglect the study of the nature of rules and their fundamental relation to the underlying beliefs which determine our conceptions of meaning and value. But it needs to be stressed that in making moral decisions we work as much toward the clarification and refinement of rules, as we work from them to our decisions. There are no static or unchanging rules.

SITUATIONS

We have already stressed how variable moral situations in clinical practice can be, and how this variability introduces ambiguity into moral choice. Each situation has to be assessed in its own terms, recognizing the different character of clinical situations in the home, in the context of general practice and in hospital. The relationships between staff and patients or clients varies considerably from one situation to the next. While the variables may seem to be infinite, we must recognize that in practice, particularly in institutions where some of the variables can be controlled, situations become increasingly standardized and hence more predictable and less ambiguous. Nevertheless moral discrimination involves, amongst other things, the ability to perceive how a given situation deviates from the norm.

PERSONAE

Health care professionals are also individuals – individual fathers or mothers, husbands or wives, or single, young and inexperienced, or older, and overconfident. They may have both administrative and clinical responsibilities. There are many factors which contribute to their personal identity, and at any one time they may be exercising several roles or have several personae. Since different responsibilities attach to different roles and different personae, moral dilemmas can arise for individuals simply because of conflicts of felt duties relating to their different personae. Moral decisions are, by their very nature, decisions which require a centred act of the whole person, and hence lack of clarity about which roles take precedence in different situations can lead to intense conflicts, uncertainty, and anxiety in crises. It is of the nature of a crisis that it demands a decision, and a decision literally means cutting out certain alternatives or cutting off certain possibilities. This an individual may not be willing to do, because of unresolved conflicts about roles, personal and vocational identity, and the expectations of others related to one's different roles and personae. To become aware of these different personae in oneself and others is an important and necessary step towards understanding the dynamics of making decisions in crisis situations and the conflicts which arise.

ARBITERS

Moral decisions are seldom, if ever, made in private. We are conscious of the scrutiny of others when we act, even if we pretend to ignore their reactions. Even in private we refer our actions and decisions to what we know others would expect of us, both those we admire and despise. Similarly, the 'pecking order' in any institution creates a hierarchy of arbiters to whom decisions not only have to be referred in practice but to whom responsibility is owed or felt. The young houseman bases his actions on the actual or imagined behaviour of his seniors, whom he admires or fears or despises. And this is

only one analogy with the primitive situation in which we refer our actions to our parents or elders for approval or criticism, and feel satisfaction or guilt according to the extent to which we succeed or fail to live up to their expectations.

These constant factors, it has been argued, form the cognitive matrices within which we have to learn to exercise moral decisions and to accept personal moral responsibility, and learning to recognize them is part of the process of our socialization. If we succeed in learning them we learn to behave in a relatively normal moral fashion. However, failure to achieve the necessary skill in recognizing these constant factors and how they operate in our moral experience is conducive to morally aberrant social behaviour.

Etiquette and ethics in professional and interprofessional relations

The second level of problems relating to the conflicts between the goals and values of different professions raises different and broader issues, but may be complicated by the fact that this domain includes the problems which arise at the first level and they may obtrude into interprofessional encounters as well, because these are *ipso facto* interpersonal encounters. Thus differences in professional outlook may be complicated by conflicts and difficulties involving personal attitudes as well, apart from personal rivalries, animosities and differences of personality.

The need for medical ethics to be studied in interprofessional contexts and by methods which focus on experimentally based group learning may seem to be self-evident. In practice most ordinary members of the professions, wishing to preserve intact their professional identity, are suspicious of the 'group dynamics' techniques which help to make us aware of professional differences and the difficulties which underlie interprofessional co-operation. Self-critical awareness of the dynamics of group functioning and the contributory factors in personal and group identity formation requires a degree of maturity in the professional and security in his profession. Otherwise methods designed to bring this about are regarded as either 'subversive' of established professional identity and traditions or inappropriately introduced to trainees who have yet to be socialized to their professions and are insecure in their professional identity. To the Victorians 'medical ethics' meant nothing more nor less than 'medical etiquette', the rules by which the doctor conducted his relationships with his fellow doctors, with members of the other professions, with his patients and with the general public. We may consider that 'medical ethics' now refers to something much more significant, but have we really progressed beyond the Victorians? Have we even begun to grasp the intricate relationship between ethics and etiquette – something the Victorians understood intuitively, when they quoted with approval 'manners makyth man'? The connexion between the ethos of a profession and the etiquette which is considered appropriate to that profession is a much more profound question than we are perhaps inclined to admit. The ethos and etiquette of a profession ideally comprehend the relationship between the values of the medical profession and conventional social morality on the one hand, and the scope and limits of permissible relationships between doctor and patient, doctor and public, doctor and professional, on the other hand (Häring, 1972).

We have lost the appreciation of the fact that etiquette reflects and expresses the way we comport ourselves in relation to the rest of society, and gives form to the subtle relationships of mutual respect and consideration which makes social existence possible. The crisis in which the caring professions stand, relative to the confusion in medical ethics, is arguably due in part to the lack of a more up-to-date and relevant professional etiquette.

Similarly, the demand for the clarification of the 'ethics' of the professions is felt as a real need because we lack what the Victorians had, namely, institutional forms which serve to give dramatic expression to and exhibit explicitly the relations between the ethos of each of the professions relative to the other and to the values of society as a whole. Whether professional ethics and etiquette can ever be defined again with the nice sense of hierarchy and form which characterized Victorian society is not the real issue. What is required is corresponding and critical recognition that questions of professional ethics and etiquette are not trivial but relate to the living context within which the more substantive issues of medical and social ethics must be examined.

The acute moral dilemmas created for medicine and the caring professions generally by recent advances in medicine and changes in society may appear to challenge the most fundamental moral preconceptions of society at large; but it is also true, and this is perhaps more important in practice, that they call into question the attitudes and values which define the limits of responsibility for the traditional and new professions. This creates uncertainty about who is responsible for what, raising questions about the relative importance of persons or principles, the authority of traditional roles or the demands for innovation to meet the novel situations. Health care professionals face conflicts between the ethos of their professions, as traditionally defined, and the kind of 'ethics' demanded by extraordinary situations. This in turn creates painful tensions between their emerging new 'ethics' and the demands of conventional social morality.

There are no easy ways out of such dilemmas. Professionals may be tempted to fall back on some strict and legalistic interpretation of the traditional ethics of their profession, or to pioneer arbitrarily new personal solutions, or to create the fiction of a new public opinion to support their case by manipulating the media. However, it is just because the tensions are so great in such areas as social and health care that 'medical ethics' has become the prime locus of the contemporary debate about moral issues.

In a sense, the prime locus of moral conflict and debate has shifted from the confessional and school, the family and the traditional authorities, to the sensitive area of encounter between the caring professions and society on the one hand and between the professions and the state on the other. The caring professions are in the middle, having to exercise serious responsibility towards those in their care and to interpret their needs and the social priorities as they perceive them to the politicians. Their dual role imposes a double responsibility. And specific moral dilemmas such as those which arise in relation to the care of the dying or to the allocation of scarce human and economic resources provoke a deep and necessary reappraisal of the ethos and etiquette of the professions and a re-examination of the relationship between the ethics of the professions and social ethics in general.

The role of ideology in the politics of professional life

The third level of problems focuses on the professional and social factors which define the identity of the professions themselves in their 'political' relations with one another, and in relation to the political and economic order, including local and national government. Whether there is a world view or philosophy intrinsic to medicine, which defines its ethos, may be seriously doubted. Nevertheless, it can be argued that historically medicine has performed the double task of attacking the superstitions of the past (often associated with religion) and in moderating the impersonal naturalism of modern science by advocating a kind of compassionate and liberal humanism. Medicine has questioned the ideology of a kind of supernaturalism which has set up an artificial dualism/opposition between man's spirit and flesh or soul and body and which has spoken of miracles as violations of the laws of nature. The ethos of medicine and the caring professions involves the attempt, however imperfect, to care for the whole man and to treat nature as a unified whole. As a consequence 'medical ethics' has always been implicitly if not explicitly at variance with the ethics of a supernaturalist theism, or has lived in an uneasy and compromised relation with it. (This has perhaps been its most profound contribution to theology, to provoke the demand for a more adequate doctrine of man.)

On the other hand, medicine has stood in an uneasy relationship with secular and naturalistic science, since medicine and its allied sciences are preeminently human and humane sciences, and have never completely lost touch with the questions of meaning and value which are crucial when we are dealing with men. The whole character of the contemporary concern with questions of medical ethics, and the demand from some quarters for the inclusion of medical ethics in the curriculum, is evidence of the drive, immanent in medicine itself, towards the formulation of a more humanistic science, a type of medicine which does not evade moral issues.

There are three senses of the word 'ideological' which are relevant to the study of medical ethics; the first relates to the 'ideological' basis of the professions and the definition of their identity and professional ethos; the second relates to the 'world view' or 'philosophy', the general beliefs which are required to support any system of values and any articulated system of ethics, and which are consciously or unconsciously accepted by men in any given society at any given time. The third relates to the more explicitly political and economic issues, the policies which govern the caring professions in their widest setting in the community and in relation to the government.

The first two senses of the word 'ideological' are closely related and are perhaps more important to the study of medical ethics. The first concerns the function of an ideology in defining the identity of a group and its ethos, the second relates more specifically to the content of such an ideology and the way it helps to specify the ethics of the profession.

It is fairly readily recognized that ideological factors in the third sense do in fact play a vital part in the political and economic conflicts which arise in the encounter between members of the caring professions, given their attitudes, goals and expectations, and the organs of local and national government, given the sectional interests they represent and the physical and economic restraints under which they operate, as well as the restraints of policy. However, what is not so readily recognized is how relevant these issues are to the way we view questions of medical ethics. Ideology in this sense provides the widest horizon of meaning within which we view the problems as they arise. Our beliefs of this kind determine what we will regard as the limits of the possible and permissible in economic and social terms. The relevance of ideological factors in this sense to medical ethics tends to emerge when we consider questions of policy with regard to the allocation of resources, with regard to future planning, or in criticism of the

'philosophy' on which the National Health Service is based.

The ethos of each profession serves the basic function of defining the collective and individual sense of identity of members of that profession, and of determining their fundamental professional attitudes, goals and expectations. However, these have to be articulated within the wider ethos of society as a whole. In this connexion the evolved ethics of a profession translates into practical terms its ethos or ideology as a group, and determines both positively and negatively its relations with other professional classes and society at large. The ordinary public, or rival professionals, are more likely to be impressed or irritated by the acquired manners and attitudes of a person in his professional role, because they experience from the outside the exclusiveness which the collective ethos of a profession gives to members of the professions, setting them apart from others. The suspicion, as Shaw expresses it, that 'all professions are conspiracies against the laity' (*The Doctor's Dilemma*) arises not only when it is suspected that doctors and others have abused their expertise and power for their own profit, but also because of the inherently exclusive character of a professional ethos (Gorovitz and MacIntyre, 1975).

The extent to which the ethos of a profession serves the positive function of giving an identity to its members and defines its ethics and has the effect of alienating members of one profession from another – frustrating interprofessional cooperation and understanding – needs to be seriously investigated, especially in those areas where difficult moral choices have to be made by members of several different professions in a common clinical situation. At this point it becomes necessary to examine more explicitly the content of the ideologies or 'philosophies' of the professions involved. What is required is not so much a narrowly philosophical analysis of the conceptual problems in medical ethics (treating it as if it is or ought to be a finished subject), but rather an approach which starts *in mediis rebus* with people in the professions concerned, and their views of the problems and their efforts to articulate the issues, working towards a clarification of the principles involved. This involves examining the ways in which representatives of the professions are predisposed by their professional training and the ethos of their professions to approach the exercise of moral responsibility. It also involves looking at those wider 'philosophical' issues which underlie ethic and ethos, namely, those issues which serve to ground and relate professional ethics in social ethics and politics, providing the framework within which members of the professions exercise their political responsibilities. This means participating in the actual historical process of dialogue which is beginning within the professions, and between the professions and the public, in which the outlines of a new medical ethics is being worked out.

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